U.S. DEPARTMENT OF COMMERCE
National Technical Information Service

PB-260 117

PROCEEDINGS OF 1960 ANNUAL CONFERENCE OF SURGEON GENERAL, PUBLIC HEALTH SERVICE WITH STATE AND TERRITORIAL MENTAL HEALTH AUTHORITIES HELD AT WASHINGTON, D. C. ON JANUARY 6-7, 1960

PUBLIC HEALTH SERVICE
WASHINGTON, D. C.

JANUARY 1960

RA 11
.P
no.771

PB 260 117
SANITARY ENGINEERING CENTER
CINCINNATI, OHIO

1960 Annual Conference

Surgeon General
Public Health Service
with
State and Territorial Mental Health Authorities

Proceedings

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPRODUCED BY
NATIONAL TECHNICAL
INFORMATION SERVICE
U. S. DEPARTMENT OF COMMERCE
SPRINGFIELD, VA. 22161

47

BIBLIOGRAPHIC DATA SHEET	1. Report No.	2.	3. Recipient's Accession No. PB-260 117
4. Title and Subtitle Proceedings of 1960 Annual Conference of Surgeon General, Public Health Service with State and Territorial Mental Health Authorities Held at Washington, D. C. on Jan 6-7, 1960.			5. Report Date Jan 60 6.
7. Author(s)			8. Performing Organization Rept. No. PHS-Pub-771
9. Performing Organization Name and Address Public Health Service, Washington, D. C.			10. Project/Task/Work Unit No. 11. Contract/Grant No.
12. Sponsoring Organization Name and Address			13. Type of Report & Period Covered 14.

15. Supplementary Notes

See also PB-260 116.

16. Abstracts

The proceedings of the 1960 annual conference of the Surgeon General, Public Health Service, with state and territorial mental health authorities are reported. Included are the presentations to the general sessions, summaries of the group discussion sessions, and recommendations of state and territorial mental health authorities.

17. Key Words and Document Analysis. 17a. Descriptors

17b. Identifiers/Open-Ended Terms

*Mental hygiene
Medical personnel
Hospitals
Outpatient clinics
State government
Public health
Mental disorders

17c. COSATI Field/Group 5J

18. Availability Statement	19. Security Class (This Report) UNCLASSIFIED	21. No. of Pages 47
	20. Security Class (This Page UNCLASSIFIED	22. Price

FORM NTIS-35 (REV. 10-73) ENDORSED BY ANSI AND UNESCO. THIS FORM MAY BE REPRODUCED USCOMM-DC 8265-P74

Proceedings
1960 Annual Conference

Surgeon General
Public Health Service

with

State and Territorial
Mental Health Authorities

January 6-7, 1960
Washington, D. C.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CONFERENCE PLANNING GROUP

1959 - 1960

Chairman: Hiram W. Davis, M.D., Commissioner
Virginia State Department of Mental Hygiene
and Hospitals

Vice Chairman: Roy L. Cleere, M.D., Director of Public Health
Colorado State Department of Public Health

Dean H. Fisher, M.D., Commissioner
Maine Department of Health and Welfare

Terrell O. Carver, M.D., Administrator of Health
Idaho Department of Health

Harold L. McPheeters, M.D., Commissioner
Kentucky State Department of Mental Health

Curtis G. Southard, M.D., Chief
Community Services Branch
National Institute of Mental Health
Public Health Service

Public Health Service Publication No. 771

UNITED STATES GOVERNMENT PRINTING OFFICE WASHINGTON: 1960

CONFERENCE PLANNING GROUP

1960 - 1961

Chairman: Roy L. Cleere, M.D., Director of Public Health
Colorado State Department of Public Health

Vice Chairman: Harold L. McPheeters, M.D., Commissioner
Kentucky State Department of Mental Health

Terrell O. Carver, M.D., Administrator of Health
Idaho Department of Health

Wilfred Bloomberg, M.D., Commissioner
Connecticut State Department of Mental Health

John H. Venable, M.D., Director
Georgia Department of Public Health

Curtis G. Southard, M.D., Chief
Community Services Branch
National Institute of Mental Health
Public Health Service

TABLE OF CONTENTS

	Page
Conference Planning Group 1959-1960	ii
Conference Planning Group 1960-1961	iii
General Session:	
Summary of Opening Remarks by Dr. Leroy E. Burney, Surgeon General, Public Health Service	1
Address: The Manpower Crisis in Mental Health by George W. Albee, Ph.D., Western Reserve University	6
Progress Report: Ad Hoc Committee on Planning Mental Health Facilities	15
Group Discussion Sessions:	
Theme: The Integration of Specialized Mental Health Programs into a Total Mental Health Program	21
Discussion Summaries	
Group I Aging	22
Group II Alcoholism	24
Group III Emotional Problems of Children Including Juvenile Delinquency, and Residential Treatment	26
Group IV Mental Health Education	28
Group V Mental Retardation	32
Group VI School Mental Health	35
Recommendations of the State and Territorial Mental Health Authorities	39
Participants in the 1960 Conference	42

Preceding page blank

Conference of the Surgeon General, Public Health Service, with State and Territorial Mental Health Authorities

GENERAL SESSION

Wednesday, January 6, 1960

(Dr. Leroy E. Burney, Surgeon General, Public Health Service, presiding.)

SUMMARY OF OPENING REMARKS BY DR. LEROY E. BURNEY

As you probably know, I have just returned from a trip to India and the Far East, where I visited the American University at Beirut; New Delhi; Karachi, Pakistan; and other places. You might be interested in knowing about some of the governmental arrangements inherited by India from the British. For example, the Indian minister of health, who is the most important person in health matters, has a secretary who is a career administrator and the second in importance. The professional man is on the third step of the totem pole and, with two levels of administrators over him, has not much to say. There are 14 states and 6 centrally administered areas in India. The Ministry of Health has a director-general of health services over the health authorities; they are quite subordinate to the career administrators. You can see that under these circumstances, professional people are subordinated to a degree unfamiliar to us.

The Indian Ministry of Health has great budget justification problems--much greater than ours. There, every expenditure must be justified up the line, through every person for every activity. Here, once we have received an allotment, we can spend it within reason.

Also, the relationships between subordinates and their superiors are different in India from what they are here. Many health authorities in India would not think of commenting on recommendations made by a superior. As you well know, subordinates in the United States usually feel free to express themselves regardless of the source of a recommendation. The situation of the Indian civil servant reminds me of the story of the little boy who had a British father and an American mother; he said he was "half and 'arf." I asked one of the health authorities if he had any criticisms to make about the operations. He had no comment except that he needed more of everything--except of human beings.

I see by the program that you will be discussing manpower needs. A recent report on medical manpower and education, Physicians for a Growing America, (PHS Publication No. 709, 1959) was developed for the Public Health Service by a consultant group headed by Dr. Frank Bane and including some 20 individuals representing professional associations, schools of medicine and public health, universities, foundations, education commissions, and the like.

This report confirmed and defined that there is indeed a shortage of physicians and dentists in the United States, and that we are falling behind in developing medical manpower adequate to our growing population and health needs. The United States has 85 schools of medicine: 81 of them offer the full four-year programs, and 4 offer the first two years. Additional two-year schools would help make up the deficit in training facilities, because their two-year program in the basic medical sciences could widen the opportunities for preclinical education and thereby allow more efficient use of clinical training facilities for junior and senior students.

New medical schools cost from $15 million to $25 million to develop, and the average basic operational cost is about $1-1/2 million a year, not including costs for research activities. This is an expensive operation.

There will be fewer physicians in the next ten to twelve years. To maintain the present ratio of doctors to population (141 per 100,000) will require an additional 3,600 graduates a year over and above the 7,400 a year now graduating from schools of medicine and osteopathy. About one-sixth of the 7,800 physicians newly licensed in 1958 to practice in this country were graduates of foreign schools.

The recommendations of the Bane committee included: (1) The Federal government over the next ten years should appropriate funds on a matching basis to meet construction needs for medical education (e.g., expanding and improving existing schools, construction of new schools of basic medical sciences, construction of new four-year medical schools and of the necessary teaching hospitals); and (2) the Nation should increase the ways and the sources for recruiting and providing assistance (educational loans, scholarships, grants) to promising medical students. The report indicated that graduate students in science fields other than medicine receive scholarship or fellowship support about three time larger by average amounts than that available to medical students.

Appropriation committees in both the House and the Senate have emphasized the provision of scholarships and other inducements that will increase manpower in professional areas now critically short; and they have asked about the kind of organizational pattern needed to carry out such a program.

Later this morning Dr. George Albee of Western Reserve University will talk about the manpower crisis in mental health, where the need is analogous to that described in the Bane committee report. Many factors influence the disparity between the demand for and the supply of skilled psychiatric talent. One of the factors is the general public's greater acceptance of mental illness and wide recognition of the value of early treatment and adequate rehabilitation. Another is the change brought about by new psychopharmacological agents and many innovations in treatment and rehabilitative measures, both as alternatives and as supplements to hospitalization.

We need not only to step up our programs of training but also to find methods of developing other personnel to take responsibility for certain levels or specific areas of service.

Training is a joint responsibility of the Federal government and the States. You can assist in several ways, among which are the following:

1. Collaborate with universities and colleges or with the regional training centers in the establishment or expansion of a variety of training facilities.

2. Set up scholarships sufficiently adequate in numbers and grant levels to attract well qualified students.

3. Establish positions with adequate salary levels and make these jobs known through widespread publicity.

4. Take an active part in recruiting young and able practitioners, and make allowance for leave of absence for advanced study.

The manpower as well as the concepts in mental health are matters of interest to programs throughout the Public Health Service--as in the Bureau of State Services' grants-in-aid and regional office activities that have to do with chronic disease, aging, nursing homes, and similar programs. In the whole field of health there is a growing concern about the assumption of responsibility for medical care--and about the development and best application of new methods, personnel, and facilities in this field.

Our concepts of patient care are changing. We are attempting to maintain patients in the local community, preferably in or near their own homes. We are adapting to the shortened hospital stay. We are considering how the discharged patient may comfortably and safely remain discharged. All this indicates the need to intensify collaborative planning and to improve communication at the local level, so that the patient may have continuity of treatment as well as the treatment of choice determined by what the patient requires rather than by what is most easily made available. There are some examples of this kind of comprehensive programming. But we must continue to work for even more effective and continuous programs that include both preventive and health protection measures for the well person and good medical care and treatment for the ill.

This leads me to research in mental health. Although basic research at universities and medical schools has been expanded during the past several years, much more of such efforts and resources is needed, along with further investment in the development of research theory and methodology related to mental health concepts. As the field of mental health attains maturity, the demand grows for a body of behavioral science knowledge that will, first, organize systematically the generalizations that have already been verified; and second, stimulate the development of new hypotheses in important areas that have not been adequately studied. Only through such a two-step process can we hope for a body of findings that can be applied to protect mental health.

With the advent of new approaches for protective, preventive, and therapeutic procedures, the expansion of program research and evaluation must follow. Concomitantly, there must be rigorous attempts to evaluate results

of both specific therapeutic interventions and the interrelatedness of various program activities.

As most of you know, the House Committee on Appropriations directed last year that the Public Health Service study and report on today's environmental health hazards. This has been done.

Just a few days ago I appointed another task force to study and make recommendations on the mission of the Public Health Service and the organizational pattern most conducive to accomplishing the mission. The group has been told to take a profound look at our aims over the next ten years. This kind of looking ahead was last done in 1934. Eight persons were selected from within the Service who have exhibited ideas and vision beyond their categorical assignments, have had broad experience, and are skeptical individuals. They are relieved of their regular official duties for a period of four months, have been given staff assistance, and told to go to work. Dr. James Hundley is chairman, and the others are Miss Margaret Arnstein, Dr. Burnet Davis, Dr. Harald Graning, Dr. Harold Magnuson, Dr. Donald Galagan, Mr. Harry Hanson, and Dr. William Stewart. Staff assistants include Mr. Allen Moore, Mrs. Margaret West, Mr. Robert Seater, Mrs. Elizabeth Pritchard, and Miss Norma Robinson. Several other experts will be added later to test some of the ideas developed by the group.[1]

We need to define growth, ideas, where we are and where we would like to go--and the best organizational pattern to carry out the aims. We must ask: What are the most efficient ways to serve people in the communities, and patients in the hospitals for mental illness or long-term illness of whatever nature; do we have the best care, or can we ever build enough hospitals to provide that care, especially for the aging, at a cost of $17,000 to $18,000 a bed? Are Hill-Burton funds the answer; or is there a point of obsolescence for hospitals? Can we afford to continue building hospitals to keep pace with our rate of population growth?

We must continuously look for ways to bring complementary or supplementary community services to the patient in or close to his home--but without duplication and overlapping of services. We should look carefully for ways to bring about better balance and coordination of services in communities that have serious lacks or too much weight in one or more program areas.

As always, we are interested in hearing your ideas and discussions over the next two days, and hope that our preparatory staff work will help to make your deliberations here satisfactory and successful.

May I make one more point on manpower--as it relates to the staff work and organization of our conference? We will respect your majority wishes but would greatly appreciate a renewed effort to find some mechanism by which the three State groups--for mental health, hospital facilities, and health officers--can join sessions at one conference. This might do much

---

[1]Later additions to the group included Mr. Sam A. Kimble, Mr. Norman E. Lindquist, Mr. Laurence E. Ring, and Mr. Joseph Murtaugh.

to consolidate our efforts in respect to the outstanding problem--the conservation of health manpower.

Now let me turn you over to Dr. George Albee, professor and chairman of the department of psychology at Western Reserve. It is a great pleasure to have him as our principal speaker.

THE MANPOWER CRISIS IN MENTAL HEALTH

George W. Albee, Ph.D., Professor and Chairman
Department of Psychology
Western Reserve University, Cleveland, Ohio

I am glad to have this opportunity to talk with you about mental health manpower, although what I have to say tends to be gloomy and depressing.

The problems of mental disorder and of our nation's growing inability to provide competent professional help for those members of our society suffering from mental disorder simply refuse to disappear, but rather show alarming signs of getting worse.

Actually, professional manpower needs in any field are largely a matter of balancing the aspirations of society against its ability and willingness to pay for the realization of these aspirations. We are in the embarrassing position of being in the midst of a mental health movement without having enough competent professional people to provide the services the movement requires and with little or no prospect that we will be able to train enough to narrow the gap between aspiration and need for the foreseeable future.

Elsewhere, I have dealt extensively with the indices of manpower needs in the mental health professions and of the poor prospects of our society for achieving any improvement in the number of available professional personnel.

Let me simply mention one or two of the most important indications of the shortage of professional personnel in the mental health fields. Our most serious understaffing exists, of course, in our public mental hospitals where most of the seriously disturbed members of our society are housed, often with only simple custodial care.

Our manpower need is not confined to public mental institutions. The needs in mental health clinics and in hospitals are equally great. In the case of clinics, for example, I have shown where we would need 2,500 trained professionals immediately to bring all our States up to the very modest goal of one mental hygiene clinic for every 100,000 people. If we were to strive to achieve the goal of one clinic for every 25,000 people, a most modest aspiration in view of the demand, we immediately see the impossibility of the problem. To try to reach this goal by 1965 would require 25,000 additional professional people, half of them in psychiatric social work and the other half divided between psychiatry and clinical psychology. There is no chance that these people will be found.

I will not take time to mention other areas of need for professional personnel beyond the simple enumeration of a few groups with which the community should be concerned: our 750,000 children with orthopedic handicaps; our 3,000,000 citizens with serious physical disabilities; the 500,000 blind or totally deaf citizens; and the growing incidence of crime and delinquency, particularly among young people. All these problems, of course,

have mental components that demand our attention and require research for prevention and alleviation.

A serious manpower shortage is in the foreseeable future in the health professions in general--and in mental health in particular. Unless positive action is taken, and soon, our citizens are going to have less professional help available in the future than they have at present. In the midst of the growing social demand for health services of all kinds, we are going to be able to offer fewer services than we now do.

In today's society, two contrary trends are evident in the whole manpower field. On the one hand, people who have had extensive specialized training are increasingly needed to keep up with our complex industrial civilization and its services. On the other hand nearly all the material products of our civilization become more and more available; because of the relative ease of obtaining all these products - symbolic of success and happiness - there seems to be a growing resistance in our young people to the painful process of acquiring skills and knowledge through serious education.

Professions come into being, or increase in number, because they meet social needs. Often they take over functions formerly performed by other social institutions. I would like to suggest that our greater reliance on professions reflects, in part, an unfortunate decline in those social institutions that formerly provided nurture and sustenance for large numbers of people now cared for by professional agencies. Let me clarify what I mean. The declining strength of the family and of the neighborhood as positive sources of support and as social controls is having terrible consequences. These consequences are evident in the juvenile delinquency rate, the feeling of rootlessness among many people, dissatisfaction with jobs, and perhaps even the decline in strength of our educational system.

I read recently a survey which indicated that one in five Americans changed his place of residence last year. We are becoming more and more rootless. I will not take time today to lambast suburbia or score the deterioration of our cities. Plenty of social critics have done this in the last few years. But I would like to note in passing that the powerful forces for stability that once existed in the neighborhood, where there were a variety of houses, a variety of families, and a variety of age groups, are rapidly being lost by our increasing standardization. Housing in our suburbs becomes more and more standardized and interchangeable, like high level motels. And in our cities, the slums spread.

The family becomes less stable as so many of its important functions are turned over to the supermarket, the entertainment industry, and paid professionals of every description.

What I am suggesting is that in our expanding population, if these processes of standardization and discrimination continue, the inevitable result will be expanded demands for professional time.

There are a number of other factors bearing upon the future of community mental health agencies that are related, but indirectly, to the population explosion. One of these factors is the urbanization trend. More and more our population tends to cluster together in urban areas. The proportion of citizens living in rural areas declines steadily. For many complex reasons, more professional help is needed where people live closer together. This may be caused by greater friction, by shortages of living space and tempers, and by extension of physical and social infections. We know, for example, that city people are less healthy, and more tense, than country people; that the rate of hospitalization for mental disorders is higher among urban dwellers, and the demand for community sponsored support is greater.

This means that as our population grows and urbanization spreads concurrently, demands for mental health services will increase at a faster rate than the population alone.

Nor is the situation likely to be improved by any crash program, nor by any clever juggling of personnel figures. The ponderous machinery of social change is not geared to rapid readjustment when extensive professional training is required. One refreshing facet in our society is our pervasive sense of optimism that all problems can be solved if only we will buckle down and take action. And it is conceivable that a nation able to mobilize itself to train tens of thousands of aircraft pilots in a few short years during World War II can likewise mobilize itself in the whole field of education. I am suggesting only that we are not likely to do so because the popular enthusiasm for education mobilization is far less than was the enthusiasm for defeating a more visible and tangible enemy. Before leaving this subject, I want to mention several other factors that deserve attention, in my opinion. First is the misleading picture we can get from manpower statistics. Usually we say there are so many professional people per hundred thousand citizens, or there are so many citizens to each trained person. The trouble with this kind of data is the implication that professional time is available equally to each citizen. I want to point out that this is not so for many reasons.

For example, there has been considerable discussion recently on the phenomenal increase in the number of residents in training in psychiatry. Let us look carefully at the situation to see whether there is cause for optimism. Last year, we are told, about 2,700 psychiatric residents were in training centers across the country. This sounds like a large number, especially when compared with 1950, when only about 1,400 psychiatric residents were in training. It appears at first glance that enrollment in residency programs has nearly doubled. But in 1950, less than 10 percent of these residents were graduates of foreign medical schools, while last year approximately 40 percent were trained abroad. Thus, more than 1,000 of our current psychiatric residents received their medical training outside the United States. There is little or no increase in the number of residents from our own medical schools. I have discussed the implications of these data in my report for the Joint Commission on Mental Illness and Health, but with little response.

We are a long way from having enough psychiatrists, and we are not training them in sufficient numbers or in places where they are badly needed. Two-thirds of all physicians now in training programs in state mental hospitals, for example, received their medical education abroad. In 11 States no one is being trained in psychiatry. Nine additional States have less than 10 physicians in psychiatric residency training. New England and the mid-Atlantic States have nearly half of all psychiatric residents in training, although these States include only about one-fourth of our population. Some 22 States had no residents last year in their State systems.

Despite the apparent increase in the number of psychiatric residents, less than 700 are reported to be in their third year of training. Using the formula I have developed in detail elsewhere, I would predict that fewer than 200 of these trained psychiatrists will be available for what we might call public psychiatry; that is, available to devote a major share of their time to non-profit agencies and institutions.

In social work the picture is just as grim. The number of graduates of schools of social work declined for several years. Although the curve now appears to be turning upward, present trends indicate the number of workers will not be sufficient for even the most conservative estimate of need. Indeed, we are losing ground rather than gaining as budgeted jobs are multiplying faster than are graduates. In psychology there is a plateau in the number of graduate students now studying, so that we can look forward only to a decrease in the number available in the immediate future and only to a slow increase in the number turned out for the next several years.

The same picture can be painted for psychiatric nursing, although here there are some rays of hope. Actually, the number of all nurses being trained is increasing at a faster rate than is our population. Thus, if a way can be found to encourage more nurses to enter the field of psychiatric nursing, the prospect of improving the manpower state in this one professional area is brighter than in most of the other mental health professions.

Shortages exist, and probably will continue to exist, in other mental health fields such as group work, occupational therapy, physical therapy, rehabilitation, and counseling.

The blunt facts are simple. We do not have enough trained personnel to handle the mental health demands of our society, and our rate of training will not meet the enlarging demands.

Why are we in this position? Why is the nation that controls half the world's wealth and has only 7 percent of the world's population unable to provide services for her mentally disordered and emotionally disturbed citizens?

Again, I suggest it is a matter of public reluctance to give up one thing for another--for many and complex reasons.

We must realize there is no absolute criterion of health needs. We are a reasonably healthy people. Since the beginning of this century,

progress in medical science has sharply cut infant mortality to about 30 per 1,000 live births and has had even more phenomenal success with older children. Only one child in 2,500 now dies between the ages of five and fourteen. Our life span continues to increase.

In many parts of the world our achievements in public health must seem unbelievable. Needs are largely a matter of aspiration. To the hungry man there is simply one shortage. But our people, for the most part healthy and well fed, aspire to better health care, and they are asking for better mental health care.

The degree to which social conditions determine human attitudes is remarkable. With more than enough goods to go around, poverty is no longer a crime. Physical illness, mental incapacity, or sheer cussedness no longer doom a man to starvation or pauperism; our sick, our handicapped, and our mentally disordered citizens can be provided for out of our surplus, and so they are.

In this respect, we should be aware that the mental health needs of the future are likely to be quite different from those we face today. Progress in our fight against disease on a variety of fronts results in changes in what we see as critical health areas. So far, we have paid relatively little attention to the training of manpower, or to research in alcoholism, mental deficiency, and gerontology.

Our country's population is growing more rapidly than is the output of our professional schools. With some 3 million added each year to the population, the demand for professional services of all kinds, including mental health services, is outstripping available professional personnel. This is not a temporary situation. Population growth is directly related to the number of women of child-bearing age (i.e., 85 percent of babies are born to women 18 to 34 years old). This means that fairly accurate predictions can be made about future population growth, at least over the next twenty years. Presently, nearly 20 million young women in our population are between the ages of 18 and 34. Ten years from now, it is estimated, there will be an additional 3 million women in this age range, and in twenty years, 12 million more.

At least two resulting characteristics of our population also affect specific mental health manpower demands. The relatively high birth rate intensifies the need for professional people in such specialties as child psychiatry, pediatrics, school psychology, school social work, child guidance, recreation work, and immunology. At the same time, the lengthening life span requires more professional services to meet the mental health problems of the aged.

In this context, it is important to emphasize a serious problem in the utilization of available personnel. Professional work with children and with the aged, or with the chronically ill and disabled throughout the age range, is apparently not attractive. In mental health and in many other fields, professional workers spend a disproportionate amount of time with young and middle-aged adults. Being human, these workers respond to the

dominant values of our culture. There appears to be a relationship between the prestige of the professional person and the prestige of his client. Because children and elderly persons tend to be less prestigeful, there is less status in work with these groups. Thus, in these areas there is a greater manpower shortage than in service to well-to-do, middle-aged neurotics.

Let me mention one other problem affecting the availability of mental health manpower - the tendency of professional people to gravitate toward and remain in urbanized areas. I have mentioned the disproportionate number of psychiatrists in training in the northeastern States. Professional service in mental health, as in many other fields, is not equally available to all citizens. In my report for the Joint Commission I emphasized the relationship between urbanization and the availability of mental health personnel. A good example here is the contrast between Connecticut and West Virginia. Both States have approximately the same population. But Connecticut has about 8-1/2 times as many psychiatrists as West Virginia. It is true that there are twice as many patients in mental hospitals in Connecticut, but it hardly seems probable its remaining citizens need this disproportionate amount of psychiatric attention. It is not urbanization, of course, that is responsible for the concentration, but rather such factors as the availability of education and training facilities, per capita income, and sophistication.

I think we also need to face the implication in data on the urbanization of professional health personnel. Either we must find motivating ways to encourage significant numbers of professional people to move away from metropolitan centers and into the rural areas, or we must devise deliberate methods for making metropolitan services available to people in the outlying areas. It may be that centralized health care in large research and treatment centers offers advantages that outweigh those of the rural and small-town all-purpose practitioner or agency to a degree that justifies devising methods to bring people to the large centers, where all may equally benefit from the concentration of many skills and resources.

The presence of a training center is important to a region in recruiting and retaining professional people. Because the disciplines with which we are concerned require many years of preparation, students tend to establish themselves in the area where they received training. Let me give several quick examples. Four times as many psychiatric social workers are in the States having schools with specialized training in psychiatric social work as are in States without such training facilities. Also, the dozen States where psychoanalytic institutes are located have some 90 percent of the country's analysts; but in the 38 States without training institutes, there are only about 10 percent of the country's psychoanalysts. There is one analyst for every 124,000 people in States with institutes, and only one analyst for every 1,262,000 people in States without institutes. Although neither ratio offers much cause for optimism so far as manpower needs are concerned, the difference between the ratios does bear out the point I wanted to make.

When will we begin to catch up with demand? I believe that if a genuine and widespread effort is made, we may be able to hold our own. But I

see little prospect of catching up with our real need. Our educational system is not prepared for a massive effort, and things are likely to get worse.

With less than 10 percent of new medical graduates entering training in psychiatry, even a sizeable increase in the output of medical schools would have little effect on the number of psychiatrists in training. Our graduate programs in psychology and social work have been through several lean years as a result of the sharp decline in the number of college graduates during the first half of this decade. Enrollments now promise to increase gradually, but shortages of instructors and supervisors are widespread.

Nursing is making rapid progress in terms of number of people trained. However, only a small percentage of nurses decide to enter a career in psychiatric nursing. Consequently, the improvement in number of nurses in proportion to the population does not help the mental health field.

Shortages of clergymen in most denominations, of occupational therapists, and of other highly trained personnel also exist.

I could talk at length about manpower problems throughout our educational system because here, I believe, is the immediate cause of prospective shortages in the professions. However, let me simply cite a few facts to give you a feeling for the dimensions of our educational crisis.

Three years ago the Fund for the Advancement of Education reported that in order to maintain our present ratio of teachers to students in the elementary and secondary schools we would need to attract into the teaching profession half of the total college graduates in each of the next ten years. We are far from attracting this large number into teaching; each year the shortage of qualified teachers becomes more marked.

Last year 11,000 physical education teachers and 3,000 math teachers were trained. The future supply of football coaches is assured. We trained more physical education teachers last year than the combined total in biology, mathematics, physics, chemistry, and foreign languages. This means that high school graduates arrive at college poorly prepared in the subjects essential to the study of medicine, psychiatry, psychology, and the basic research disciplines underlying most of our applied professional fields.

At a time when we are faced with rapidly rising college enrollments, the loss of qualified faculty members at colleges and universities continues. It has been estimated that between 300,000 and 400,000 faculty members must be found over the next twelve years not only to replace those who die, retire, or leave the field, but also to take care of increased enrollments. Currently, fewer than 4,000 recipients of doctorates enter academic teaching each year. We are simply not going to have competent faculty people available to teach the young people we do attract to higher education. Current shortages of candidates for responsible teaching positions in medical schools and other professional and graduate schools are growing.

Only about one-third of the brightest 20 percent of our young people now graduate from college. Thus, we are losing two-thirds of the youngsters most likely to profit from higher education and to be attracted into the sciences and professions. Whenever I read about the doubling of our college population over the next decade I realize that higher educational institutions will be so overtaxed that little or nothing will be done to encourage the bright young people with high ability but with insufficient money or motivation to go on to higher education.

A complex civilization such as ours, with high aspirations for the health and welfare of its citizens, must depend on highly trained and highly educated manpower. Our educational system cannot now supply this manpower, and things are going to get worse before they get better.

Possibly the sense of urgency that is developing will result in an effort to train greater numbers of professional people in the next few years. But the population problem is not going to be handled by a single effort. We will continue to grow, and - barring a change in attitudes in our society - the institutions designed for the production of professional skills will not be equal to the prospective endless strain of keeping pace with population growth.

What can we anticipate in the way of necessary organization of mental health agencies? Agencies are simply people working together in an organizational structure. The projected shortage of professionally trained people certainly has implications for agency administrators, some of whom may be nonprofessional. The need to discover ways to reach more people with fewer professional staff suggests that time-consuming, individual, face-to-face contacts, and especially repeated contacts, will yield to other methods. This may mean more emphasis on group methods, on the use of technicians and other less highly trained personnel in greater supply, and it certainly means that we need to focus on preventive research and large-scale therapeutic techniques.

Periods of shortage tend to be periods when professional training requirements are raised rather than lowered. This is a natural consequence of concern over the use of poorly trained personnel. I think great care is needed in defining the training requirements in mental health, so as not to set non-functional requirements. We must remember the very direct relationship between the degree of shortage in a field and the length of the required training period. We should remind ourselves constantly that there is not necessarily a relationship between the prestige of an activity and its usefulness to society. In searching for functions within each of our disciplines, I think we have had a tendency to shy away from anything not defineably unique.

What we need are techniques and methods that will enable each professional worker to reach far more people. If we do not now have such techniques, then we had better spend time looking for them. The logic of our present manpower situation makes any other solution highly unrealistic.

I would emphasize the proposition that efficient use of mental health personnel requires methods to supplement the time-consuming, face-to-face relationship between a single professional person and single patient. I do not know what these methods will be. The number of the people who need help and the number of people prepared to give help are out of proportion. Perhaps we must look to epidemiology for guidance. Just as typhoid fever was never brought under control by treating individual cases but rather by discovering and taking steps to remove the source of the disease, so we may find greater effectiveness in prevention, research, and other public health approaches.

Other problems in the utilization of professional personnel are important. Most of us will agree that a listing of needs for professional services in health agencies compared with a listing of present professional activities would reveal many discrepancies. For me, the outstanding example is the disproportionate amount of professional time spent with middle-aged neurotics as against the relatively little time spent with children. The facts show the greatest shortage of professional people is found in the area of working with children. Once again, I suggest that there is no necessary relation between the prestige of an activity and its usefulness to society. For many and complex reasons, working with children in public agencies serving children carries less prestige than many other activities. We need to change this situation, perhaps by increasing the material rewards, but more likely by influencing the climate of opinion within our professions. Similar discrepancies exist in the areas of crime and delinquency, alcoholism, mental retardation, and mental illness.

Finally, I would emphasize that over the long range our best hope is for research breakthroughs into the causes and prevention of mental disorder. We are on an endless treadmill of numbers and needs unless we can reduce the number of people requiring mental health services by preventing the disorders before they appear. It may be that the only hope is to concentrate our energies on the training of research personnel, even if this results in a reduction in the training of practitioners and a temporarily graver shortage of practitioners.

I apologize for bringing such a gloomy perspective to what apparently is a friendly and good-humored meeting.

PROGRESS REPORT
AD HOC COMMITTEE ON PLANNING MENTAL HEALTH FACILITIES

Presented by Harold L. McPheeters, M.D., January 6, 1960

As Dr. Burney mentioned, an Ad Hoc Committee on Planning Mental Health Facilities was appointed last August as a follow-up of a recommendation made at the March 1959 conference of State mental health authorities. The committee is composed of representatives of the State hospital survey and construction authorities and State mental health authorities.

My assignment today is to present a progress report reflecting the action of the committee at its first meeting held in Washington last October 12-13 and the activities to date.

At the opening session of our October meeting, Dr. Burney addressed the group and explained that the committee's primary purpose is to develop a basis for improved planning of mental health facilities. In carrying out this objective, the committee will recommend treatment and administrative guidelines to be used as the basis for more realistic planning and programing of the construction of mental health facilities. These principles would be in keeping with modern concepts of treatment. Dr. Burney pointed out that there is an increasing recognition of the magnitude and importance of the problems of mental illness. The recent development of new techniques of treatment and care, he said, requires a revaluation of the nature and availability of the physical facilities necessary for a comprehensive program of treatment and care.

Areas of Activities

Four broad areas of activities were proposed by the committee. First I shall list these areas, after which I will go into further detail about each activity. They are:

1. Identification of the newer and proven concepts of treatment of the mentally ill;

2. The development of useful and more reliable means of determining the facility needs for the several types of mental illness;

3. The development of guidelines for translating the needs into a coordinated system of community and statewide services; and

4. The consideration of staffing and administrative problems.

Now for a further breakdown of each of these areas.

The first activity listed was identifying the newer and proven concepts of treatment of the mentally ill. Three major points will be considered in this connection.

First, it has been proposed that a survey be made of recent trends as well as the extent of the current need for treatment and care of mental illness. The changing rates of incidence and prevalence for each type of mental illness will be considered.

Next, we plan to study the changing concepts in the treatment of the mentally ill. The effectiveness of present treatment as well as anticipated trends will be reviewed. Some of the areas to be given special consideration are:

a. The development of techniques for early recognition and early treatment of mental illness;

b. The advantages and disadvantages of treating the mentally ill on an outpatient basis;

c. The advantages and disadvantages of having psychiatric units in general hospitals; and

d. The need to develop rehabilitative and minimal care and treatment programs--as well as home care services--as transitional stages between acute treatment and return to society.

The third item under the first major topic has to do with the current care and treatment of "para-mental" groups. These include the senile aged, the mentally retarded, and the emotionally disturbed. Such consideration would be necessary in developing an over-all approach to the problem of mental illness.

The second general category mentioned has to do with developing more reliable means for determining facility needs.

Among the items to be studied under this heading would be resources currently available to meet present needs. This would include an analysis of the number of mental hospitals beds, their utilization, and the characteristics of the present population in mental hospitals.

Attention also should be given to the impact of changing concepts of treatment upon the need for and nature of facilities to implement these treatment methods. In this connection, consideration should be given types of facilities recommended for early diagnosis and treatment, intensive care, rehabilitative treatment, and long-term custodial care. The need and utilization of facilities for special categorical groups, such as the mentally retarded and the senile aged, also would be reviewed.

The third general category has to do with developing a coordinated system of community and State-wide services.

It was decided that definitive guidelines be established for developing such systems that would include programs for constructing specific facilities required for providing these services. As a prerequisite to developing these plans and programs, a critical revaluation should be made of the indices of need currently in use so that more sensitive indices for each type of mental disability might be developed.

In addition, basic principles should be developed for planning the construction of facilities needed to meet State-wide and local community needs.

The fourth general activity deals with staffing and administrative problems.

One of the broad topics falling into this area is a study of current financing patterns for the care of the mentally ill and how these patterns might be affected by the changing concepts of treatment. In the field of construction of facilities, consideration will be given to ways of achieving more effective use of Federal funds made available under existing or expanded programs.

Consideration also will be given the question of the legal and moral responsibility for supporting programs to prevent, treat, and care for the mentally ill. Recommendations may be made with regard to the need for legislative and organizational changes in areas affecting the basic patterns of care and treatment.

Still another subject in this general category of staffing and administrative problems is the question of availability of qualified personnel. A competent staff is needed to operate a system of facilities and services adequate to meet current and anticipated needs in the field and to develop necessary training programs.

And, finally, there is the need for continuing research in developing more effective patterns of treatment of the mentally ill, in terms of both services and the facilities needed to provide these services.

Principles

In the course of delineating the areas of study, several tentative principles were proposed and will be revaluated during the course of the study. It was suggested that additional principles which will evolve during the study will also be recommended by the committee. Tentative principles proposed are:

1. Mental health programs should place increasing emphasis on prevention, early recognition, and early treatment of mental illness.

2. Increased emphasis should be placed on rehabilitation of the mentally ill and preparation for complete return to home and society at the earliest feasible time.

3. Long-term custodial care in mental institutions should be prescribed only as indicated following application of intensive treatment techniques.

4. Construction of new facilities should be based upon the current concepts of treatment and expected future development.

5. Facilities for treatment should be located in terms of easy accessibility to the area of potential need.

6. Treatment should be suited to the patient's needs and the patient should be referred to the facility most appropriate to his needs. Greater emphasis should be placed on continuity and progressiveness of care.

7. Facilities should be used for the purpose for which programed and staffed, and at the highest levels of efficiency.

8. Facilities for the mentally ill, both as to location and type, should be programed and constructed in accordance with a comprehensive State-wide plan which provides for a coordinated pattern of service.

9. State-wide planning for mental health should represent a joint effort by State and local, public and private agencies concerned with mental health.

10. Care and treatment of the senile aged, mentally retarded, and emotionally disturbed should be considered as a part of the State and local mental health program.

11. Higher priority should be given to a mental health facility that is a part of or closely affiliated to a general hospital or health center, and to a new facility rather than to a proposal for remodeling an existing facility.

12. In the interest of providing more effective service to more people, facilities should be designed and utilized to serve multiple needs, when this is consistent with sound treatment practice.

13. Construction design should be flexible, to permit future expansion or modification to other uses, particularly in psychiatric units of general hospitals.

Committee Report

As provisionally outlined by the committee, the report will include recommended goals of a well-planned mental health program and the most feasible methods for their attainment; trends and opinions regarding new concepts of prevention, care, treatment, rehabilitation and after-care; and

principles of programing and administration that would be useful in developing a coordinated system of community and State-wide services and facilities.

Staff work is being performed as a joint activity by the Community Services Branch of the National Institute of Mental Health and the Division of Hospital and Medical Facilities. Basic statistical data and other informational materials are now being compiled on the extent of the problem and on the resources, staffing, and methods of treatment currently in use.

The date of completion of the final report, and its submission to the Surgeon General, has been tentatively set for January 1961.

Wednesday, January 6
Thursday, January 7
1960

STATE AND TERRITORIAL
MENTAL HEALTH AUTHORITIES

GROUP DISCUSSION SESSIONS

THEME

The Integration of Specialized Mental Health Programs
Into a Total Mental Health Program

Group I	Aging
Group II	Alcoholism
Group III	Emotional Problems of Children Including Juvenile Delinquency, and Residential Treatment
Group IV	Mental Health Education
Group V	Mental Retardation
Group VI	School Mental Health

Preceding page blank

SUMMARIES OF GROUP DISCUSSION SESSIONS

Group I - Topic: Aging

Leader:	Dr. Hiram W. Davis	Virginia
Recorder:	Dr. V. Terrell Davis	New Jersey
	Mrs. Daisy A. Bayton	District of Columbia
	Dr. Robert D. Higgins	North Carolina
	Dr. Harry C. Solomon	Massachusetts
	Dr. Wilfred Bloomberg	Connecticut
	Dr. Daniel J. Hurley	Nevada
	Dr. John M. McKee	Alabama
	Dr. Edgar J. Easley	Arkansas
	Dr. H. Wallace Lane	Washington
	Dr. Robert A. Haines	Ohio
	Mr. Vernon A. McGee	Texas
	Dr. Paul H. Hoch	New York
	Dr. Joseph P. Russell	Missouri
	Mr. N. T. James	Oklahoma
	Mr. T. Ray Kingston	Utah
	Dr. Robert T. Hewitt	NIMH, Bethesda, Md.
	Dr. Jerry W. Carter	NIMH, Bethesda, Md.

Group I devoted its deliberations to the problem of the aging population and its relation to hospital and community mental health programs. It was apparent that there is a necessity to outline the role of the State mental health authority in assisting communities to develop resources for the aging. There was general feeling that this role should be limited to the provision of facilities for the mentally ill or the mentally incompetent aged. Other problems of the aged should be referred to the proper community resources but the mental health authorities should remain available for consultation and leadership in the areas of their special professional competence.

The increasing magnitude of the challenge of our aging population makes it imperative that we mobilize resources for the prevention of disabilities in the aging and the resultant necessity of mental hospitalization. Effective methods for such prevention do not now exist. There was strong feeling within the group that the necessary research and study of this problem require broad interdisciplinary approaches with a major emphasis on social planning. This should not be the sole responsibility of the mental health or public health authority. Reference was made to the commissions on aging which exist in many States and to the current development of special committees for the 1961 White House Conference on Aging.

Four areas of research approaches to disabilities in the aging were pointed out as follows: metabolic, clinical, social, and psychological performance capacities, responses and attitudes. It was stated that considerable data must be collected before comprehensive educational programs could

be undertaken, even if we may assume that education is the best available general avenue for the prevention of mental disability in the aging.

It was pointed out that there is further need for clarification of just what our problems are with regard to the mental hospitalization of the aged. Some aging mentally incompetent individuals require custodial care or nursing-home type services, and in some instances are committed to State hospitals due to lack of other resources.

Most of the States in this group were experimenting with ways and means of using nursing-home facilities, chronic medical care facilities, and other community resources in addition to mental hospital facilities to provide more appropriate care for the senile, aged incompetent. It was the general opinion that the care of these individuals should not be the exclusive responsibility of the mental health departments of the States, but requires close collaboration with local health and welfare resources. There appears at this time to be no one best method of dealing with this increasingly significant problem.

Examples were given of the development of geriatric units in connection with tuberculosis and chronic illness hospitals.

An eighty-bed unit for elderly incompetent individuals was licensed by the health department and run by a department of mental health. In this manner the individuals were entitled to old-age assistance benefits.

Another State was utilizing nursing homes to provide care for selected patients from mental hospitals.

The group explored the extent to which hospitals in the United States had developed day hospitals or reception centers which were available to the aged mentally ill. It found considerable interest in many States, but actual programs were operating only on a limited basis in a few States and with the superficial impression that such facilities were preferable to full hospitalization. In many cases these new resources could take the place of full hospitalization for these individuals. It is our recommendation that further serious programing in this area be pursued in as many States as possible.

The discussion brought out the difficulty in determining the effectiveness of new procedures and programs of treatment of the mentally ill if one expects to base the determination on a decline in hospital admissions. Many other factors are contributing to a relentless increase in the number of applicants for institutional care.

Foster home placement or family care programs for the aging, as well as other mental hospital patients, are finding increasing usefulness but are limited primarily by the difficulty in securing foster homes and the difficulty in recruiting the necessary social workers to supervise the programs. There was unanimous agreement that foster home placements had their merit only if they were able to provide a better life for the patient than that

provided in a mental hospital. They should not be seen as a substitute for a hospital bed.

Summary:

The increasing number of people over 65 in the general population, and the reflection of this in the increasing percent of patients over 65 being admitted to mental hospitals, highlights the urgent need for realistic planning for the medical care of this group of our population, as well as for social planning in the field of geriatrics. Aging is not primarily a mental health problem, and the infirmities of old age are not primarily a psychiatric problem. However, mental health directors will have to take the initiative in stimulating other medical and social groups to creative planning and action.

Group II - Topic: Alcoholism

Leader:	Dr. Bernard Bucove	Washington
Recorder:	Dr. Perry F. Prather	Maryland
	Dr. Caroline A. Chandler	Maryland
	Mrs. Frances Roberts	Connecticut
	Dr. Estelle A. Magiera	Mississippi
	Dr. Richard A. Pasewark	Wyoming
	Dr. D. G. Gill	Alabama
	Dr. Harry S. Howard	Delaware
	Dr. Henry V. Guhleman, Jr.	Missouri
	Dr. Margaret DuBois	Ohio
	Dr. W. C. Allen	Missouri
	Dr. Carl L. Anderson	NIMH, Bethesda, Md.

The group looked at the questions listed for discussion and started with question No. 3, which had to do with responsibility. The question is: In the development of an alcoholism program, is the State mental health authority responsible? Discussion then led to the matter of agency responsibility, and the question of special commissions was discussed. It was pointed out that the history of these commissions is that after functioning for a while, a number of them have been abandoned. Connecticut, Oregon, Tennessee, and California, after experience, have decided that perhaps alcoholism should be within a mental health authority or the health department.

It was the consensus of the group that it is a healthy sign that alcoholism is now being considered as an illness, but the group was a little hesitant to define whether it is a mental illness. It is a nebulous sort of thing, with no one taking hold and developing a program. Many agencies are interested, such as courts, departments of welfare, mental health authorities, and health departments--but which of these should be the coordinator or the responsible agency to develop programs was not decided. The group was in definite accord that mental health authorities do have a responsibility.

Next came question No. 2, which the group rephrased to read as follows: What is the public health agency's role in the development of a program on alcoholism in those States where the agency does not have the primary responsibility? Several roles were discussed, such as the part played by the public health nurse, the nutritionist, in public health education, prevention, and in consultation. There was considerable emphasis on the fact that the public health nurse is of great value, particularly in giving supportive services to families in which there is an alcoholic.

The next question discussed was No. 4: What effective current efforts and activities have been developed on control and treatment of alcoholism?

A number of efforts were listed and agreed upon by the group as having had effectiveness, at least to some degree. Among them were the Yale summer school scholarship program, the multidisciplinary treatment centers, the AA, in some areas police farms such as the Seattle Alcoholism Farm, social workers especially trained to work with alcoholics in magistrate's courts, and information centers. The group felt that there was potentiality, at least, in education programs directed at young people; and that where special institutes for teachers have been held, as in Mississippi, there was great interest on the part of teachers.

The group then discussed question No. 1: What services need to be planned for a program on alcoholism? Among those discussed were professional education, as well as education to other workers interested in the field; beds in general hospitals for acute alcoholics, but especially in the teaching hospitals; welfare services; rehabilitation services; social services and other ancillary services that would be of great value to patients and their families.

It was suggested that it would be quite helpful to all interested in alcoholism programs if the Public Health Service would make available a directory of psychiatric outpatient clinics for alcoholics. It was explained by Dr. Carl L. Anderson (of NIMH) that there is good reporting on all such clinics if a psychiatrist is the director, but if someone other than a psychiatrist is director (and the psychiatrist is a consultant) reporting of these clinic services is incomplete. It was suggested that even these should be listed so far as possible, as well as any other programs assisting alcoholics.

In discussing services, personnel, and facilities, it became apparent that in effect the group was discussing mental health services in which there was an alcoholism component and similar services directed specifically to the single problem area.

The need for program evaluation and research in the area of alcoholism was likewise discussed.

Group III - Topic: Emotional Problems of Children Including Juvenile Delinquency, and Residential Treatment

Leader:	Dr. Terrell O. Carver	Idaho
Recorder:	Dr. Stewart T. Ginsberg	Indiana
	Dr. William P. Hurder	Southern Regional Education Board
	Mr. Charles Leonard	Connecticut
	Dr. Gerhard B. Haugen	Oregon
	Dr. Lynwood M. Hopple	Colorado
	Dr. William H. Hall	District of Columbia
	Mr. Cecil R. Wurster	Louisiana
	Dr. Leonard J. Ganser	Wisconsin
	Dr. Richard J. Lilly	West Virginia
	Dr. Joseph E. Cannon	Rhode Island
	Dr. Warren T. Vaughan, Jr.	Western Interstate Commission for Higher Education
	Mr. Arthur S. Funke	Vermont
	Dr. James W. Osberg	PHS, Regional Office IV
	Mrs. Ruth I. Knee	NIMH, Bethesda, Md.

The group attempted to arrive at a definition of the term "emotionally disturbed children." The consensus was that this is a term used to describe many types of emotional reactions including many different diagnostic categories, rather than an entity in itself. These children with emotional problems are recognized by their family or by the community as having abnormal behavior. From a psychiatric diagnostic standpoint, many of the children fall into our standard diagnostic nomenclature and should be diagnosed when examination makes this possible. They have a wide variety of backgrounds and etiological factors and require intensive and varied treatment, utilizing all available resources.

Although the problem is recognized as being serious for the individual child, family, and all facets of the community, we do not have reliable information on the number of children with emotional problems. We need more information about the number, distribution, and severity, as well as about who is taking care of them and what is being done for them. Also, we need additional information about their unmet needs. Many children who are reported as having emotional disturbances and in need of treatment, receive no treatment because the recommended facilities are not available. Follow-up studies would be very helpful to learn what happens to these children who need but do not receive treatment. Do they develop more serious emotional problems or do they adjust, and if so, at what level of adjustment?

Emotionally disturbed children vary from those with the mild emotional disturbances of all normal children through those with increasing severity of disturbance to the point where their maladjustment becomes apparent to themselves, their families, their teachers, or the community. Families themselves cope with the mild emotional problems of children. Counseling and guidance services may be sought by the family. As the emotional disturbance becomes more advanced, the services of health and welfare agencies

as well as psychological testing and evaluation in the schools become necessary. The family physician is a resource for recognition, evaluation, diagnosis, and treatment of the child. Community psychiatric clinics may be utilized. As the emotional disturbance is recognized as more severe and as the environmental situation requires, the child may be removed from the home to a foster family or to a residential home, and day hospital services may be utilized. Some children are so emotionally disturbed that they require institutional care and treatment. It is believed that some children do well in a State hospital setting, some in a special children's unit and others on a ward with adults. Special institutions for disturbed children play an important role for selected patients.

The discussion of services in a sparsely populated region brought up the role of the regional community clinic. Many of the western States have large areas with no local health or welfare agency. It was felt that continuing services for emotionally disturbed children could be obtained by working through the local physicians. It was emphasized that there is need for evaluation, diagnosis, and understanding of these children. Any resource in any area must be utilized to implement and initiate solutions to problems of emotionally disturbed children. A family service agency may be effective. The local agency may function only as a referral agency. It was believed that coordination of all resources is extremely important. The psychiatric services could well be incorporated into a community health clinic, strengthening the total public health services. There was considerable expression of opinion that these rural services should be a part of a public health program.

This field is so vast and varied that we need all available facilities and coordination with all other agencies having to do with children. There was agreement that where community resources are already serving children with emotional disturbances it is better for them to continue with such services. Consultations may be offered. It would be a disservice for a new agency to assume responsibilities already being carried in a community.

In discussing the role of the community hospital, it was agreed that more psychiatric services are needed. If a general hospital has a psychiatric service and psychiatric staff, children with psychotic emergencies or severe emotional disturbances can be treated locally. Some States are stimulating the development of psychiatric units in general hospitals by reimbursing a hospital for the care of psychiatric patients.

The question of whether mental health authorities should assume responsibility for the treatment of emotionally disturbed children in penal institutions was discussed. It was felt that the mental health authority should have sufficient contact with correctional institutions to assist them in developing a treatment oriented program and to make sure that there is adequate opportunity for transfer of more seriously disturbed children to proper psychiatric treatment units.

In discussing manpower shortages it was the feeling that as treatment becomes more specialized our limited manpower becomes more diffused and less effective. There was emphasis on the importance of coordination. It was

believed that manpower shortages may force us into more effective coordination of services.

It was agreed that it is very difficult to evaluate the effectiveness of our child guidance clinics and preventive measures. Studies are needed on the effectiveness of various methods of treatment and rehabilitation. We should apply the techniques on hand in keeping with our present knowledge, but must make every effort to improve our techniques of treatment and rehabilitation.

On an optimistic note, it was recognized that we are learning more about children. New ideas are being developed. We focus on stress and the level of adjustment to life situations. The emotionally disturbed child is one who makes a pathologic adjustment to life's stress. The severely disturbed child is one whom the family and/or the community recognizes as in need of outside help. Treatment is based on the life span. The goal of treatment is to help the child to a better resolution of the crisis at the moment and to help him meet life's problems in the future.

In summary, there is much that we need to know about the emotional problems of children. Much research is required, particularly evaluative studies on treatment programs, testing of new programs, the follow-up of children, including those who have not received treatment and those who have received treatment. Pilot programs in new techniques are required. States should recognize the importance of the problem and should be encouraged to create programs and services at the community level and in the State hospital setting. Services for children with emotional problems can be provided by a wide variety of facilities, resources, and agencies. It is essential that all available resources be utilized into a coordinated effort to develop effective evaluation, treatment, and rehabilitation.

Group IV - Topic: Mental Health Education

Leader:	Dr. Roy L. Cleere	Colorado
Recorder:	Dr. Lester M. Libo	New Mexico
	Mrs. Leila N. Myers	Kansas
	Mr. C. J. Eugene	North Dakota
	Dr. Yan Tim Wong	Hawaii
	Dr. Wayne Yaeger	Florida
	Mrs. Dolores G. La Caro	Puerto Rico
	Dr. John T. Herron	Arkansas
	Mr. E. Roy Rogillio	Louisiana
	Mr. Charles Rosenblum	Louisiana
	Mr. J. T. Ellis, Jr.	Texas
	Mrs. Eldra L. Shulterbrandt	Virgin Islands
	Dr. Harold M. Hildreth	NIMH, Bethesda, Md.
	Miss Pearl Shalit	NIMH, Bethesda, Md.

Several basic questions were raised early about defining the goals, selecting the media and audiences, and measuring the effectiveness of mental health information-education programs. Some of the questions were: Do we know what kind of information we want to disseminate? What is the difference between information and education? Whom do we educate and toward what goal? How do we measure the impact of the information-education program?

This soul-searching about basic definitions and aims led to the formulation of Group IV's sole recommendation: that the Public Health Service sponsor a survey of information-education programs in the various States and prepare a report of practices and a manual of procedures, with special emphasis on measures of effectiveness. It would be useful to have data on the experiences of the States with various types of media and program personnel, how the program was initiated, how it was carried out, what communication channels were used, how evaluation of effectiveness was conducted, and with what results.

The following six areas of program operation were discussed:

1. Selection of Content to be Disseminated or Taught.

There was a difference of opinion as to the adequacy of existing knowledge and skill concerning educational technique, but there was complete agreement that the greatest problem is a question of values, in selecting what attitudes are to be changed and what skills are to be learned. The content to be taught might best be selected on the basis of the needs and interests of the audience group. For example, county agricultural agents are confronted often with questions and concerns about human relations problems of the people they serve (rather than exclusively with livestock-raising, plant diseases, cooking and sewing). The content of a mental health program for these rural leaders might well involve community organization and group dynamic principles to help them and their "clients" to identify their concerns more effectively.

2. Experiences with Specific Methods.

The discussion covered the following:

a. Mental health films (more effective with colleges than secondary schools);

b. Slides (useful for reports on visits to facilities such as open hospitals in England);

c. Individual pamphlets, pamphlet series, and packets;

d. The forming of special organizations (a teen-age auxiliary of a mental health association helped deal with a local juvenile delinquency problem);

e. Role-playing (served as "immunization" for a group of pre-delinquents; role-playing of delinquent behavior helped them feel what it

would be like and seemed to make it unnecessary to try out the same kind of behavior in the community);

f. Planned contact with mental health personnel in informal settings (in a recreation program for adolescents a psychiatrist participated with them in informal, social contact and helped them see him as accessible and quite human);

g. Discussion guides and manuals (for groups without professional mental health leadership, can warn lay leaders not to inject their own biases, to stick to the proper material, and resources recommended);

h. Bulletins and newsletters (for general distribution or on special topics mailed to special groups);

i. Clinical service as the core of the educational effort ("one satisfied parent or patient can educate a lot of other people"; the personal experiences of former patients of Veterans Administration hospitals can help interpret mental health practices to the other members of veterans' organizations); and

j. Training workshops (sponsorship can well be shared with university personnel, and should take advantage of special skills of educators. A recommended practice is to start with a joint session of the mental health professional leaders with key personnel in the group for whom the program is designed--such as law enforcement officers--who can provide the mental health education personnel with valuable information about existing knowledge and practice).

3. Experiences with Strategic Groups.

Among the many community groups and professional disciplines which have been considered for mental health education programs, in addition to the usual ones such as teachers and clergymen, are such groups as sheriffs (on the recognition and handling of acute disturbances), state police (on the handling of drunken drivers), county agricultural and home extension agents (on family relations and child development), trained and partially trained workers in the mental health professions, juvenile court judges, recreation workers, credit investigation representatives, and labor union stewards (who can assume leadership in health programs when they are sponsored by their parent unions).

The necessity of carefully defining roles and preventing the practice of amateur psychiatry was noted, but at the same time are we honestly prepared to accept these other groups as strategic? Can mental health program specialists guide them to do better jobs in their roles without becoming threatened that our important roles are being shared? Can we be quarterbacks and not always have to carry the ball of direct treatment, especially in view of Dr. Albee's grim forecast of the serious manpower shortage?

4. Channels of Dissemination.

The power structure of the group and differences in social class and culture should be observed. Labor union education programs with mental health content can make effective allies of shop stewards when health programs under the sole auspices of management and the plant's medical department may fail to get employee interest.

In dissemination of health information to ethnic minorities, fraternal and church organizations are sometimes better vehicles than "outside" health agencies.

In a rural mental health education program, the first workshop held was with all the county extension agents. Later, when public programs were planned in each county, the agent was an ally in enrolling his people, interpreting the mental health education program, and working more closely with the mental health specialists in carrying out the program in his home county area.

In a pamphlet series on the prenatal period, obstetricians were involved from the start. Every medical society mental health committee chairman could well be approached and made acquainted with public program goals and resources.

5. Organization of the Mental Health Education Agency.

A disagreement arose concerning the advisability and logic of coordinating all mental health programs within one agency or commission. It was agreed that a structure is always needed for getting to the grass roots. In some areas local welfare departments are the traditional carriers of this function; in others, local health departments; in others there is greater State-level direction. It was considered doubtful whether a comprehensive community mental health program, which involves health, welfare, education, law enforcement, and a host of other agencies and programs, can ever realistically be incorporated within a single agency or commission. There would always be the need for communication and collaboration between programs. Nevertheless, this could not be achieved through an administrative structure alone.

The group then asked: "What really is an integrated mental health program?" If we can clearly define all the activities and functions relative to the handling of a particular mental health problem, then treatment (for example, in an aftercare program) could itself be used as a medium for education, rather than artificially distinguishing it as an activity separate from prevention.

6. Evaluation of Effectiveness.

Methods cited ranged from saving letters from grateful pamphlet readers and the use of reaction sheets from information packet users, to studies of learning and retention, to the use of actual changes in health practices. In a study of PTA groups, a great deal of interest in mental health

information was shown, but retention of the material presented was largely dissipated within twenty-four hours. Now the program leaders use intensive two-day sessions, and follow-ups within three to six months. To encourage more concern with the problem of the effectiveness of health education programs, we might try to share leadership with university faculties and other workers with research interests.

Group V - Topic: Mental Retardation

Leader:	Dr. Daniel Blain	California
Recorder:	Dr. David J. Vail	Minnesota
	Dr. Franklin M. Foote	Connecticut
	Dr. Robert M. Fink	North Carolina
	Mr. Joseph J. Majors	Maine
	Miss Florence S. Dunn	South Dakota
	Mr. W. L. Couch	Illinois
	Dr. V. A. Stehman	Michigan
	Dr. John H. Venable	Georgia
	Dr. Daniel J. Hurley	Nevada
	Dr. Forrest E. Rieke	Oregon
	Dr. Harold M. Skeels	NIMH, Bethesda, Md.

In accordance with the request of Dr. Curtis G. Southard, the group first gave specific consideration to a proposed amendment to the Federal social security laws or a revision of the procedure to facilitate the inclusion of convalescent mentally ill patients in public assistance programs. The proposal that Section B of the present clause be eliminated was approved. The proposal that Section A be modified as suggested to read "in a hospital" rather than "in an institution" was approved in principle. It was felt, however, that the latter suggestion was not specific enough and could be subject to interpretation to the detriment of convalescent patients still on the hospital records of a mental institution but not actually residing in the hospital. Accordingly, it was suggested that the wording be amended to state "physically residing in a hospital."

The group next gave its consideration to its major topic of concern; namely, mental retardation. It was emphasized by way of preamble that mental retardation should be included in all considerations of mental illness and mental disorder as a major subject of concern to the mental health professions. It was pointed out that of last year's official recommendations all but three had significant implications for the field of mental retardation. It was further stated that mental retardation is listed as one of the seven major categories of mental disorders in the Standard Nomenclature pertaining to diseases of the psychobiological unit.

The feasibility of integrating services for the mentally retarded with other mental health services at the local level was considered. In this connection the problem of adequate diagnostic facilities was discussed. It was agreed that the minimum services provided should include not only casework and psychological services but, most importantly, those generally

needed for the rendering of skilled medical diagnosis. In this instance medical diagnosis includes not only basic medical or pediatric considerations but also specific attention to neurologic and psychiatric problems.

It was pointed out that the mentally retarded tend to fall into limbo, since child guidance clinics as usually constituted are frequently not motivated or staffed to provide a comprehensive screening service for the retarded. Pediatric clinics on the other hand often do not have available the specialized neurologic and psychiatric skills necessary for the purpose.

A further problem in establishing a comprehensive mental health service to include the mentally retarded is the resistance sometimes found among influential lay groups, such as parents' groups, to having mental retardation included among mental health problems, and their frequent insistence that this be treated as an entirely separate issue. The suggestion was made that the staff of a community mental health center could be enlarged specifically to include a professional person, such as a social worker, whose responsibility would be to coordinate diagnostic and treatment services for individual cases of this group. This person would be responsible to the program director in his own local operating unit. The group agreed that by whatever mechanism it could be accomplished, services for the mentally retarded should be integrated with general mental health services, preferably at the local level. The services should stress comprehensive diagnostic screening at early stages to include medical, educational, and social evaluation.

Consideration was given to techniques of integration. The specific question was asked, "Who is responsible for integration of services for the mentally retarded with general mental health services?" It is believed that integration of services should be the responsibility of the competent State agency dealing with the mentally retarded. The agencies should be encouraged to stimulate local leadership. Where services for the retarded at the State level are divided, there should be coordination of services hopefully with the evolution of some unified leadership at the State level upon which local initiative should be based. In this connection the Departmental Committee on Mental Retardation of the Department of Health, Education, and Welfare is cited as a model. This operates under the chairmanship of Dr. Joseph Douglass from the Office of the Secretary and includes representatives from the Office of Education, the Office of Vocational Rehabilitation, the Children's Bureau, and the National Institute of Mental Health. This Committee each year publishes reports of progress in the field of mental retardation and a listing of grants made in the field by the Department.

Consideration was given to vocational rehabilitation services for the mentally retarded in institutions. It is believed that more information should be made available to the States concerning the availability of Office of Vocational Rehabilitation services for the mentally retarded and the procedures whereby these services can be obtained. It is further emphasized that State institutions must maintain commensurate adequacy of their own social service departments.

Responsibility for providing adequate school programs for the mentally retarded should be shared by States through the State department of education as well as by local (county and municipal) school systems. In a more abstract philosophical sense, it was agreed that the State has responsibility for education of the retarded. Local and private resources should be developed and encouraged but the State should use its authority to enable additional programs to develop.

The question of whether education for the trainable retarded should be mandatory was touched on, but the group took no position. The group agreed that at the institutional level, genuine treatment programs are preferable to custodial care programs. In the final analysis this appears to hinge on the attitude of the superintendent and his staff concerning treatment and rehabilitation prospects for the mentally retarded. If possible, efforts should be made to educate the public to realize that some measure of treatment and rehabilitation is actually possible for the mentally retarded, so that the people to whom program directors are responsible will demand progressive programs as their right. It is recognized that institutional programs will be increasingly handicapped by virtue of the fact that institutional commitments increasingly consist of the more severely retarded and infirm patients. At the community level it was stressed that treatment should be directed to the family and neighborhood through the resources of social workers, public health nurses, and county welfare personnel.

Consideration was given to the problems of the mentally retarded and borderline adult patient both in institutions and in the community. The group expressed its belief that this is a seriously neglected area. Community and government efforts in behalf of the retarded have tended to concentrate on problems of retarded children at the expense of others in this category. The committee believes that there should be a thorough survey of needs and problems of the adult retarded and social resources available to them.

The responsibilities of various medical and other professional groups relative to prevention and services to the mentally retarded were considered. It is believed that before these professionals can be expected to take a full measure of responsibility they must first be thoroughly indoctrinated in the principle of prevention and care of the mentally retarded. Therefore, in the first instance it is the responsibility of mental health authorities to provide this education. The serious question was raised on whether the psychiatric profession itself is at this time equipped to provide this leadership.

The group expressed the belief that pre-service and in-service training programs for nonprofessional personnel in the care of the mentally retarded should be developed. It is recognized that demands on personnel will differ in relation to the type of caseload; i.e., personnel providing care for severely retarded and infirm patients will be faced with different demands from those presented to personnel providing social or family type care for active and physically healthy educable cases. Nonetheless, it was the consensus of the group that pre-service training programs should be developed to produce reservoirs of ancillary nursing personnel, such as practical nurses who would thereby achieve some measure of professional status.

Group VI - Topic: School Mental Health

Leader:	Dr. Harold L. McPheeters	Kentucky
Recorder:	Dr. Trawick H. Stubbs	Georgia
	Dr. George W. Metcalf	District of Columbia
	Dr. Wilber A. Mitchell	Kentucky
	Dr. Abraham Zeichner	Connecticut
	Mrs. M. Opal Fore	Iowa
	Mr. Charles S. Mitchell	Texas
	Dr. Carl A. Bramlette, Jr.	South Carolina
	Dr. Geoffrey M. Martin	Kansas
	Mr. Jack Steneck	Idaho
	Dr. William G. Hollister	NIMH, Bethesda, Md.

Dr. Hollister provided members of the group with a school mental health kit which is available to all members of this conference. This includes Reference Guide No. 2, available in any number desired by the mental health authorities.

Several basic questions were raised: Are we concerned with the prevention of mental illness or with early casefinding? By the time a child enters school, are the determinants of future mental illness already present? Do schools do some things which promote illness and can these be avoided? Some would object that the school's function is educational and that it should not have a mental health program. Are we really talking about a community mental health program for school-age children? What is the relation of school mental health to the school health program? Is the emphasis on illness or on the promotion of health? Is it possible to separate factors which promote intellectual and social growth from those which promote emotional health? Does the difficulty of measuring results limit the types of activities which are practical for school mental health programs?

Reference was made to positive concepts of mental health and to such ideas as tolerance of stress, self-realization, and increased productive capacity, and the total process of contributing to personality growth as contrasted with prevention of illness. Concern was expressed for prevention of maladjustment, unhappiness, etc., as well as prevention of illness.

The complexity of the field calls for limitations and goals that are not too global. An example is the Quincy, Illinois, study of reading disability perceived as a type of cultural deprivation. The field includes services to those with special needs as well as services to total school populations. The program must begin where the school is; and includes work with faculty as well as pupils. Many school people tend to view workers as professionals concerned with mental illness only. Actually, much of the school program concerned with the application of the science of human behavior has been identical with what we refer to as "mental health." It is important to identify the growing edge of applied behavioral science in school systems and to help persons working at the edge of this horizon to

close the gap between what is known and what is practiced by the behavioral scientist.

There is a definite relation between school health programs and school mental health programs, but many aspects of school mental health lie outside the activities of the school health program and involve personnel that do not have direct responsibility for school health programs.

School mental health involves concern not only for individuals but also for health of social groups and social systems. Priority of activities depends on what door is open in the school system, and also on what doors we knock upon. Teacher workshops were referred to as a revolving door.

Rather than working directly with individuals in trouble, professional mental health staff are increasingly spending time in consultation with teachers and other professionals who, in turn, work with individuals. Some school people ask for a list of symptoms to help them recognize early trouble. This need of early recognition calls for a more comprehensive approach than providing checklists. Concern with program is more important than activities.

Environmental health surveys should include consideration of the health of the teacher and the impact of the teacher on the children. This can be encouraged by health departments (Kansas was given as an example).

Teacher-training methods are important and should emphasize first-hand observation of child growth and development. Various programs in colleges of education were discussed.

It is important to bridge the language barrier between mental health professionals and educators and to recognize that "behavioral understanding and behavioral guidance" may be the same things we refer to as "mental health." The role of the State mental health authority involves responsibility to encourage an adequate school mental health program, but not necessarily to participate in the operation of the program except on a consultant basis.

Instead of simply referring to the number of children in a class, it might be well to refer to the number of interpersonal relationships that a teacher must supervise.

Very few States have in their education department a single coordinating office for the various aspects in the total educational program that deal with mental health. There is an important advantage in thinking of school mental health as an integral part of the major educational effort, rather than relegating it as one of the special services only.

It would be helpful if each State gathered together the curriculum outlines in the various courses which have mental health implications, particularly home economics and other such courses not labeled health or mental health courses. There was considerable discussion of the categories summarizing "State Mental Health Activities by State Mental Health Authorities."

In discussing programs for identifying and screening disturbed children, it was pointed out that the 7 to 14 percent average does not involve the same individuals, and much research is needed to determine which individuals continue to have problems and why. Considerable discussion centered around each of the resolutions.

RECOMMENDATIONS

OF THE

STATE AND TERRITORIAL

MENTAL HEALTH AUTHORITIES

Thursday, January 7, 1960

Preceding page blank

The Conference recommends:

1. Amendment of Social Security Laws

That the Secretary of Health, Education, and Welfare propose to the Congress legislation to amend existing social security laws so that they do not discriminate against persons with any type of illness, mental or physical, and in the meantime that the present wording of the portion of the Social Security Act governing public assistance benefits be interpreted so as to specify that only individuals physically residing in a mental hospital be excluded from assistance benefits.

2. Admission of Alcoholics to General Hospitals

That the general hospitals, particularly teaching hospitals, be encouraged to admit alcoholics for treatment.

3. Orientation in Alcoholism Activities

That the Public Health Service be requested to provide short courses involving personnel from several States in appropriate places throughout the country to give instruction and orientation in the development of alcoholism program activities.

4. Integration of Community Services

That, wherever appropriate, alcoholism services be incorporated with other community activity and that mental health centers, if they are not now serving alcoholics, be encouraged to do so.

5. Research Program for the Emotional Problems of Children

That the Public Health Service provide leadership in working with the States in research on emotional problems of children, particularly evaluative studies of ongoing programs, testing new techniques and follow-up studies of treated and untreated children.

6. Survey of Mental Health Information and Education Practices

That the Public Health Service conduct or support a survey of current patterns of mental health education and information programs of the various States with particular attention to program content, staff, techniques, evaluation methods and results and to publish a report which can be used as a resource manual to be made available especially to the State Mental Health Authorities.

7. Integration of Services for the Mentally Retarded with Other Medical and Related Services

That the Public Health Service encourage the development of comprehensive diagnostic and treatment services for the mentally retarded integrated with other medical and related services at the local community level.

8. Services for Mentally Retarded and Borderline Adults

That the Public Health Service investigate through sociological and epidemiological studies the needs of mentally retarded and borderline adults and the resources available for them.

9. Education and Training of Personnel in the Field of Mental Retardation

That the Department of Health, Education, and Welfare emphasize in its training and assistance programs the subject of mental retardation. This applies to the various appropriate specialities in medicine and other related professions and to nonprofessional groups serving the mentally retarded.

10. Future Considerations of Mental Retardation

That mental retardation be included as a major agendum at the 1961 Conference of the Surgeon General with State and Territorial Mental Health Authorities.

11. Distribution and Collection of Information Regarding School Mental Health Activities

That the State Mental Health Authorities be supplied with copies of the report "School Mental Health Activities of State Mental Health Authorities" and that each State Mental Health Authority be requested to provide supplementary information about its activities in the school mental health area to be included in a periodic revision of this report.

12. Joint Activity of the State Mental Health Authority and the State Department of Education in Developing School Mental Health Programs

Whenever feasible, that the State Mental Health Authorities take the initiative in establishing appropriate liaison mechanism with Departments of Education so that they can together, in a mutual relationship, and on a joint basis, analyze and develop the comprehensive school mental health programs in the State.

13. Expansion of the Staff for School Mental Health Consultation

That the staff for school mental health consultation services of the Community Services Branch be expanded in order to provide more intensive services to the States where a need for additional services exists.

14. Expansion of Training Resources for School Mental Health Personnel

That the Public Health Service expand the programs for the training of school mental health personnel.

15. Contracting for Special Studies in School Mental Health

That the Public Health Service be encouraged to contract for special studies in school mental health programs.

Participants in the 1960 Conference

Dr. George W. Albee
Dr. W. C. Allen
Dr. Carl L. Anderson

Mrs. Daisy A. Bayton
Dr. Daniel Blain
Dr. Wilfred Bloomberg
Dr. Carl A. Bramlette, Jr.
Dr. Bernard Bucove
Dr. Leroy E. Burney

Dr. Joseph E. Cannon
Dr. Jerry W. Carter
Dr. Terrell O. Carver
Dr. Caroline A. Chandler
Dr. Roy L. Cleere
Mr. W. L. Couch

Dr. Hiram W. Davis
Dr. John Davis
Dr. V. Terrell Davis
Dr. Margaret DuBois
Miss Florence S. Dunn

Dr. Edgar J. Easley
Mr. J. T. Ellis, Jr.
Mr. C. J. Eugene

Dr. R. H. Felix
Dr. Robert M. Fink
Mr. Edward J. Flynn
Dr. Franklin M. Foote
Mrs. M. Opal Fore
Mr. Paul E. Fox
Mr. Arthur S. Funke

Dr. Leonard J. Ganser
Dr. D. G. Gill
Dr. Stewart T. Ginsberg
Dr. Henry V. Guhleman, Jr.

Dr. Robert A. Haines
Dr. William H. Hall
Mr. Harold P. Halpert
Dr. Gerhard B. Haugen
Dr. John T. Herron
Dr. Robert T. Hewitt
Dr. Robert D. Higgins
Dr. Harold M. Hildreth
Dr. Paul H. Hoch
Dr. William G. Hollister
Dr. Lynwood M. Hopple
Dr. Harry S. Howard
Dr. William P. Hurder
Dr. Daniel J. Hurley

Mr. N. T. James

Mr. T. Ray Kingston
Mrs. Ruth I. Knee
Dr. Thaddeus P. Krush

Mrs. Dolores G. La Caro
Dr. H. Wallace Lane
Mr. Charles Leonard
Dr. Lester M. Libo
Dr. Richard J. Lilly

Dr. Estelle A. Magiera
Mr. Joseph J. Majors
Dr. Geoffrey M. Martin
Mr. Vernon A. McGee
Dr. John M. McKee
Dr. Thomas B. McKneely
Dr. Harold L. McPheeters
Dr. George W. Metcalf
Mr. Charles E. Mills
Mr. Charles S. Mitchell
Dr. Wilber A. Mitchell
Mrs. Leila N. Myers

Dr. James W. Osberg

Dr. Richard A. Pasewark
Dr. John D. Porterfield
Dr. Perry F. Prather

Dr. Forrest E. Rieke
Mrs. Frances Roberts
Mr. E. Roy Rogillio
Mr. Charles Rosenblum
Dr. Eli A. Rubenstein
Dr. Joseph P. Russell

Mr. Wilbur J. Schmidt
Miss Pearl Shalit
Dr. Clarence M. Sharp
Mrs. Eldra L. Shulterbrandt
Dr. Harold M. Skeels
Dr. Harry C. Solomon
Dr. Curtis G. Southard
Dr. V. A. Stehman
Mr. Jack Steneck
Dr. Trawick H. Stubbs

Dr. G. D. Carlyle Thompson
Dr. Manuel A. Torres-Aguiar

Dr. David J. Vail
Dr. Warren T. Vaughan, Jr.
Dr. John H. Venable

Dr. Yan Tim Wong
Mr. Cecil R. Wurster

Dr. Wayne Yaeger

Dr. Abraham Zeichner

☆ U. S. GOVERNMENT PRINTING OFFICE : 1960 O - 555686